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OPTIMIZING PHYSICIAN SERVICES TO IMPROVE CONSUMER ACCESS IN A COMMUNITY MENTAL HEALTH CENTER

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SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
CPM 2009

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STATE DOCUMENTS

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Charleston/Dorchester Mental Health Center is one of 17 strategically placed Community Mental Health Centers. The Charleston/Dorchester Mental Health Center's (CDMHC) mission is to provide treatment for and to promote the recovery of persons with serious mental illnesses as well as children and families with serious emotional disturbances, and to provide care for those in psychiatric crisis. This mission is in keeping with the South Carolina Department of Mental Health (DMH) value providing care in the consumer's local community.

Since 2005, the CDMHC has had significant reductions in the operating budget and faces even more dramatic and drastic cuts this fiscal year. The CDMHC has dealt with these budget cuts in many ways including decreasing or eliminating programming, hiring freezes and attrition of staff, increasing work week to 40 hours and therefore increasing generation of revenue, and decreased spending. Another major concern to the agency is that due to changes in Medicaid standards, revenue has sharply declined over the past several years and further significant reductions in Medicaid revenue are expected. This decline in earned revenue adds to the challenges created by the cuts in state appropriations. In these difficult financial times, it is extremely important to look at ways to use all resources efficiently and effectively and to minimize effects to consumers.

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PROBLEM STATEMENT

Consumers, in advisory board meetings with the CDMHC Executive Director, report dissatisfaction with the amount time available for appointments with their physician, i.e., report feeling rushed. Wait times to return for a medication check or symptom check for consumers who are in active treatment is too long by report of physicians, mental health professionals, and consumers. Initial PMA, psychiatric medical assessment, of consumers who are new to services at CDCMHC are currently at 8 weeks or more. Consumers that are recent hospital discharges can not easily be fit into a schedule to see a physician. Emergency needs for assessment or involuntary commitment are scheduled into already crowded schedules.

Physicians are the most expensive personnel resource of the Center and recruitment of psychiatrists is difficult in the public sector as salaries are not in line with federal or private health organizations. In the last 18 months, 5 out of 12 physicians have center, 3 of those to take federal positions which pay significantly more. Two positions have been replaced, one with a 0.8 FTE and the other with an Advanced Practice Registered Nurse (APRN).

With decreased numbers of physicians but no decrease in the numbers of consumers, consistently around 3,000 open records in the center at any given time, the need for increased hours available for medical checks by existing physicians is needed. It is the expectation of this investigation that increasing direct services by physicians is achievable to provide more access for consumers.

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OVERVIEW OF MENTAL HEALTH TREATMENT – PHYSICIAN SERVICES

Providing direct services to consumers is an expectation of all front-line clinical staff, and the CDMHC staff provide services both in clinic and in the community. In most services areas or teams, consumers are served by multi-disciplinary teams that include physicians and mental health professionals. Benchmarks were set in 1999 productivity, or billable hours for all staff, and determinations were made as to the expectations depending on the position and the extraneous demands of the position, i.e. stationed out in the field, number of and/or travel time to home visits, supervisory duties. The percentage of time determined and expected for physicians to provide billable clinical services to clients was set at 55% and 50% for APRN's.

By Department of Health and Human Services (DHHS) standards, physicians are required to assist with the plan of care and approve medical necessity of services for consumers provided by mental health professionals and nurses. Physicians are responsible for diagnosis and for prescribing medications. The CDMHC has chosen to employ APRN's, who can prescribe medications, excluding some controlled substances, but they are not credentialed to approve plans of care or services provided nor to make or change a diagnosis. However, for the purpose of this project, I will consider them equal to physicians/psychiatrists as they provide a PMA billable similar to physicians.

Referrals to treatment at the clinic come from several sources, including hospital discharges, self, family requests and other health or mental health providers. All consumers that seek treatment at the mental health center are provided an initial intake by a specialized team that performs triage of phone calls and requests, referrals to other

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sources, if appropriate, conducts initial intake assessment of all new clients, and emergency walk-ins, or hospital commitments, and participates in field response, if able, especially with request from law enforcement.

A complete clinical assessment is done upon intake that includes interviewing family members, a psychosocial exam, and a medical history, as well as current reasons for seeking care. The initial intake is generally completed in the clinic but may be done at a local hospital for those who may be difficult to engage in treatment or in the field, if the intake team provides mobile response in the community. At that point, an initial Psychiatric Medical Assessment (PMA), scheduled with the physician at a later date. The initial intake PMA is scheduled for a 60 minute slot and the show rate for initial PMAs are 50% based on data kept by the intake team.

Current DHHS standards dictate that the first physician appointment must be within 90 days of the initial clinical assessment by an MHP. After this appointment, the next contact with the doctor would most frequently be scheduled by the assigned case manager according to the parameters set by the physician in the initial intake PMA.
The follow-up PMA is then scheduled in a time frame as determined by the assessment of need by the physician, generally for a 30 minute appointment, anywhere from 1-3 months.

Previously, a .75 FTE physician was assigned to this intake/mobile crisis team.
As resources have retracted, this position was not filled when vacated. The duties for this function have been divided between the physicians who are scheduled to see ongoing PMAs and the hour intakes are incorporated into their schedules. In addition to PMAs, mental health professionals and physicians can bill a consultative service, Service Plan

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Development or SPD, that is for treatment plan development or change in services provided or physician recommendation for focus of treatment.

Until February 2008, physicians were separated in two clinics, one serving primarily adult consumers and the other serving children and families. There has been an overall decline in the demand for children services. The two clinics were integrated into one clinic and teams merged for fiscal reasons as well to create efficiencies and improve clinical care of families. This merger created the ability to access care from more physicians and child physicians were oriented to adult treatment and given the expectation to see all clients of the mental health center.

Physician supervision has currently been a duty of the medical director and scheduling completed with input of clinical supervisors. Physician scheduling is fragmented at best. Physicians are assigned to a regional case management team or to the intensive case managements teams, as well as various other small specialized program areas such as the Homeshare program and Co-occuring state initiative grant (CO-SIG). A large amount of physician time is scheduled in public schools as part of school based services and 1.5 days of physician time is allotted to the local Drug and Alcohol Services clinic. Twelve hours of physician time weekly are contracted with the Charleston County Detention Center to provide treatment for inmates where no billing occurs. Twenty-eight hours of child physician time are "traded" with MUSC child outpatient services and replaced with physicians that primarily treat adults and 20 of those hours are dedicated to clinical services, and the remainder to CDMHC's crisis stabilization unit. In addition, the mental health center contracts with 3 physicians for a total of 20 clinical hours per week.

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The cost of physician time is between $75-100 per hour. An APRN costs the center an average of $73,000 annually, and is about half the salary and benefit cost of the average physician salary. An APRN can provide a similar service of PMA-APRN, evaluating consumers and prescribing medications and can be reimbursed at a rate of $52 per 15 minutes unit fee versus unit fee of $62 for physician. The CDMHC has recently filled a full-time physician vacancy (Kithianis) with an APRN as it is evident that this is a cost-effective position.

In looking at the data that follows (see Attachments B, C, and D), one would need to know the differences of positions and what the services physicians are actually performing. Three of the physicians work a 30 hour work week (Taylor, Smith, Scott), three are "traded" to provide children services with the Medical University Institute of Psychiatry for physicians who provide adult services (Taylor -12 hours, Smith -7.5 hours, McTighe – 5 hours). One performs non-billable services for the mental health center team which provides an employee assistance type program for the City of Charleston Fire Department (Scott) but is reimbursed through a contract with the City of Charleston. One (Spencer) has a very high rate of out-stationed work in schools.

Revenues rates for physicians are easily accessible but in investigating differences in revenue I determined that while revenue is important to the overall business of the center, revenue is more dependent on the population served and the degree to which the consumers served by an individual physician are entitled by Medicaid and Medicare. The center pays for local hospitalizations of unfunded consumers and cost-shares in placements of children and adolescents so serving consumers at a sliding scale self-pay rate, often at $2 per service, rather than having them seeking emergency care in local

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emergency departments, hospital care, or out-of-home placements is important financially as well as meeting our mission of providing mental health care to those in the community.

Attachment A shows the broad differences in funded consumers of various teams or programs. **Attachment C** represents the Medicaid revenue of physicians.

When looking at the data to determine the possibilities of increasing direct services by physicians, patient show rates were examined. With each "no show", the cost of care increases and the wait for consumers needing to receive care is longer. The recommended target standards for no shows are 25% for initial intakes and 10% for continuing appointments (Lloyd, 2002, p.246).

Show rates were kept for the adult clinic by paper and pencil counting from the existing schedule for the day. Shows rates were not kept for the child and adolescent clinic and, after integration, show rates were only kept for clinic based appointments. **Attachment B** shows the show rate of physicians. With the recent addition of electronic medical records (EMR) in October 2008, and EMR roll out to out-stationed clinics and staff scheduled soon, the ability to schedule electronically and ability to track real show rates will be achieved.

In effort to improve show rates, clients are called by administrative staff the day prior to their appointment, however some clients do not answer, some do not have ability to receive messages, some phone numbers are inaccurate, some phones are no longer in service, or simply some clients do not have phones. While this procedure has been in place since 2002, when administrative staff experience staff shortages, procedures were not always followed.

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Additionally, once a client is determined not to be coming to their appointment, there is no consistent process to backfill that appointment or even to inform team members, who may be able to reschedule them. It became apparent that no one was really managing the schedule of the physicians and much of the time, neither clinical staff nor team leaders were looking at schedules in advance. There are no waiting lists kept. In discussing physician scheduling with case managers, there appears to be no consistent process in re-scheduling those who do not show up for consecutive appointments

The mental health center has required productivity logs to be submitted by all billing staff, including physicians. Contract physicians have not routinely submitted information but are expected to begin doing so in January 2009. These logs account for sick and annual leave as well as official and training leave. Official leave includes services that are performed but are not billable revenue for the center such as the Fire Department team, jail services, and court requirements. The logs are self-reported and weekly as well as monthly averages are reported to supervisors and the management team. **Attachment D** represents the productivity of physicians. This measurement seems to be the most accurate and the fairest representation of the productivity of physicians. It provides supervisors timely feedback. Supervisors must check the self reports against actual billing reports from centralized data reports that are available after billing has been submitted to ensure accuracy.

Repeated requests of the physicians to do time studies on non-billable activities were not very successful so physicians were asked in a brainstorming meeting and in structured interviews what unbillable activities they most often performed and what tasks could be reassigned to allow them to see more consumers, as well as to identify other

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barriers that prevent direct consumer contact. The following tasks were identified in a brainstorming meeting and in face-to-face interviews with physicians as the most prevalent tasks: documentation, writing needed prescriptions, pre-authorizations for medications for insurance companies, hunting for information or people, travel time, filling out other medical necessity forms, faxing and other administrative duties (**see Attachment E**).

In addition, while the Medicare prescription benefit has helped many access vital medications, it has made things very difficult for treatment providers. The same could be said of the new Medicaid HMO's. Medical staff have been spending more time on paperwork and on repeated calls to the prescription plans.

When a physician goes out to an out-stationed school clinic, they are not available to help with emergencies, walk-ins, writing of needed prescriptions, or to staff clinical needs with MHPs. This puts the majority of the burden for non-billables on those who are stationed in the clinic.

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PROPOSAL

In having physicians outline their most time consuming non-direct service related duties, one would conclude that the assignment of these tasks, if able, would provide additional time for physicians to provide services. At a 55% productivity for a full-time position, 20.625 weekly hours are available, which would allow about 35 clients to be seen. If one additional hour per day could be made available to see consumers by designating duties to others, physicians could increase their productivity to 66% and could potentially see 8 to 10 more clients per week.

I propose assigning nurses to regional case management teams and locating them close to where the physician offices are located. Some interventions are billable by nurses but not by mental health professionals. Nurses may do health teaching and assessment that nonmedical staff cannot perform. They can follow-up telephonically with consumers to check on medication efficacy and side effects. With the determination that prescribed medications are working, time between physicians' visits might be lengthened while maintaining the quality of care.

Nurses would write and document in records needed prescriptions, identified by case managers, based on previous medication orders and would research records to complete prior authorization forms to obtain medications. Physicians would still be required to review, check, and authorize via signature but this certainly would decrease the time spent by the doctor. Nurses could also complete lab requests and obtain samples for physicians to label. They could meet with consumers immediately prior to physician visits to obtain needed vital signs such as weights, blood pressures, and body mass index.

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Nurses would be able to bill for a portion of this time as a nursing service at a unit fee of $51.00. The productivity of this position will have to be determined but an estimate of 40-45% would be a good starting point.

I also propose assigning an administrative position to a regional area to support both the nurse and the physician as well as other clinical staff in performing clerical duties. This position will be a reassignment from a data entry position no longer required with implementation of electronic medical records. Tasks such as faxing, "hunting" down of hard records, including hospital or other reports, assisting with the "management" of physician schedules, acting as a customer service representative, calling clients to remind of appointments, filling in of cancellations and rescheduling, sending letters to no-shows, could all be performed by administrative personnel.

This position could also relieve case management staff of clerical duties. Workflow and internal communications would also be enhanced with daily feedback to team members and supervisors by both of these positions. With implementation, I would propose that a full-time physician would be able to bill 10% more or 3.75 additional billable hours per week and increase revenue to the clinic by about $7,000 per month.

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IMPLEMENTATION AND EVALUATION

Due to budget cuts during this project, our center has determined we must close two programs, the crisis stabilization unit and the day treatment program on February 1, 2009. With the displaced nursing and administrative positions, I will be able to implement this plan without hiring any additional staff. The ability to retain staff to serve consumers is a win-win situation, however unfortunate the loss of valuable programming for consumers.

Two of the nursing staff that will be displaced will move to a more clinic like arrangement and be medical assistants to the physician and consumers. One administrative position will be available with program closures and the other position will be taken from the medical records department as the implementation of EMR has decreased the need for as many paper records required to be pulled on a daily basis and a decrease in the previous billing mechanism that required data entry by administrative staff.

Position descriptions and planning stages will need to be written to outline the specific tasks that need to be performed to achieve efficiencies outlined. Policies must be developed for administrative staff for consistent response for no-shows. Procedures for implementing a waiting list must be outlined. Staff will have to be oriented and trained in their specific duties. The nursing supervisor will train the nurses and the regional team leaders will train and supervise the administrative position.

The biggest hurdle may be the physician's resistance to change. An effort will be made to make sure that they understand why these changes are taking place and the reasons for performing increased direct services is not to make them work harder but to

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provide the necessary face to face time with consumers that only they can provide. The more the physician team feels supported and feedback heard during the transition the better.

Comparisons of show rate data will be an indicator of efforts of this plan to increase the patient show rate. If show rates increase, it will be important not to overload physician schedules to allow for breaks. Continued monitoring of productivity of physicians will clearly show if this plan indeed achieves what it is intended to achieve. Increased revenue should follow increased billable services.

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SUMMARY AND CONCLUSION

With the frequent changes and adjustments occurring due to fiscal cuts in state government, accountability and efficiency become more important in maintaining quality services. In behavioral health, personnel are extremely important as treatment services are the main product of business and treatment can not be provided without them. Physicians are the most expensive, and also a very necessary, component of the treatment team. Looking objectively at ways to enhance service capability while maintaining or improving clinical care is key. By providing close and timely support of duties and tasks that others could do and having all staff work to their expertise, direct services by physicians will be increased and access to services by consumers will be enhanced while quality is maintain.

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ATTACHMENT A

CHAS/DORCH COMM MENTAL HEALTH

Caseload Report
11/17/2008

OFFICE		Total Clients	Medicaid Entitled	Medicaid %	Oct. -08 Admissions	Oct. -08 Discharges
		16	5	31.3%	2	1
740	CHARLESTON CENTER CAF CLINIC	44	26	59.1%	5	0
755	HOMESHARE	22	21	95.5%	0	0
717	HOMESHARE YIT	2	2	100.0%	0	0
744	LIBERTY HILL ACADEMY	45	38	84.4%	2	1
752	LWSUM ADULT ASSERTIVE CASE MGT	222	88	39.6%	3	11
775	TEAM 5 (ACT LIKE TEAM)	45	16	35.6%	0	0
732	TRICOUNTY CRISIS STABILIZATION CENTER	20	6	30.0%	22	14
771	UPPER N CHAS ADULT CASE MGT	40	23	57.5%	1	1
768	UPPER N CHAS SCHOOL BASE	75	64	85.3%	5	11
786	WAC COSIG INTAKE	88	20	22.7%	6	4
743	WAC DIRECT REPORTS LCC	93	83	89.2%	32	26
734	WAC FORENSIC SVCS MENTAL HEALTH COURT	42	17	40.5%	2	1
774	WAC INACTIVE	19	5	26.3%	0	1
737	WAC MEDICATION CLINIC	38	18	47.4%	0	0
730	WAC MOBILE CRISIS/INTAKE	15	0	0.0%	18	0
761	WAC MOBILE CRISIS/INTAKE	0	2	0.0%	0	21
783	WAC OOHP	16	15	93.8%	0	1
757	WAC PACT TEAM 3	163	112	68.7%	4	0
751	WAC PACT TEAM 4	186	154	82.8%	6	2
785	WAC REGION 1 BABYNET	39	33	84.6%	6	0
763	WAC REGION 1 HOMEBASED	39	11	28.2%	3	0
71	WAC REGION 1A ADULT CASE MGT	264	128	48.5%	4	9
781	WAC REGION 1A SCHOOL BASED	42	35	83.3%	3	3
79	WAC REGION 1B ADULT CASE MGT	293	112	38.2%	2	4
78	WAC REGION 1B SCHOOLBASED	73	61	83.6%	14	2
76	WAC REGION 2A ADULT CASE MGT	196	116	59.2%	1	0
760	WAC REGIOIN 2A SCHOOL BASED	69	60	87.0%	11	3
749	WAC REGIOIN 2A WRAPS	16	10	62.5%	0	0
75	WAC REGION 2B ADULT CASE MGT	175	106	60.6%	5	1
728	WAC REGION 2B SCHOOL BASED	8	6	75.0%	2	0
712	WAC REGION 2B VOCATIONAL SERVICES	0	0	0.0%	0	0
738	WAC REGION 3A ADULT CASE MGT	255	146	57.3%	5	5
74	WAC REGION 3A CAF CLINIC	5	5	100.0%	0	1
747	WAC REGION 3A HOMEBASED	14	14	100.0%	0	1
742	WAC REGION 3A SCHOOL BASED	70	56	80.0%	7	2
739	WAC REGION 3B ADULT CASE MGT	79	42	53.2%	1	1
759	WAC REGION 3B CAF CLINIC	69	47	68.1%	1	5
745	WAC REGION 3B SCHOOL BASED	80	70	87.5%	11	1
716	WAC REGION 4 HOMEBASED MST	0	0	0.0%	0	0
770	WAC REGION 4A ADULT CASE MGT	146	80	54.8%	3	5
758	WAC REGION 4A DSS	34	27	79.4%	2	3

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780	WAC REGION 4A FETTER CLINIC		11	5	45.5%	2	0
764	WAC REGION 4A SCHOOL BASED		24	18	75.0%	3	0
766	WAC REGION 4B ADULT CASE MGT		132	76	57.6%	1	0
750	WAC REGION 4B DJJ		62	41	66.1%	15	21
782	WAC REGION 4B SCHOOL BASED		54	45	83.3%	10	2
714	WELLNESS ACADEMY		1	0	0.0%	0	0
718	YIT		16	11	68.8%	0	0
	Totals for the Center:		**3457**	**2076**	**60.1%**	**220**	**164**
		Adults	**2811**	**1463**		**113**	**108**
		Children	**1424**	**1130**		**173**	**112**

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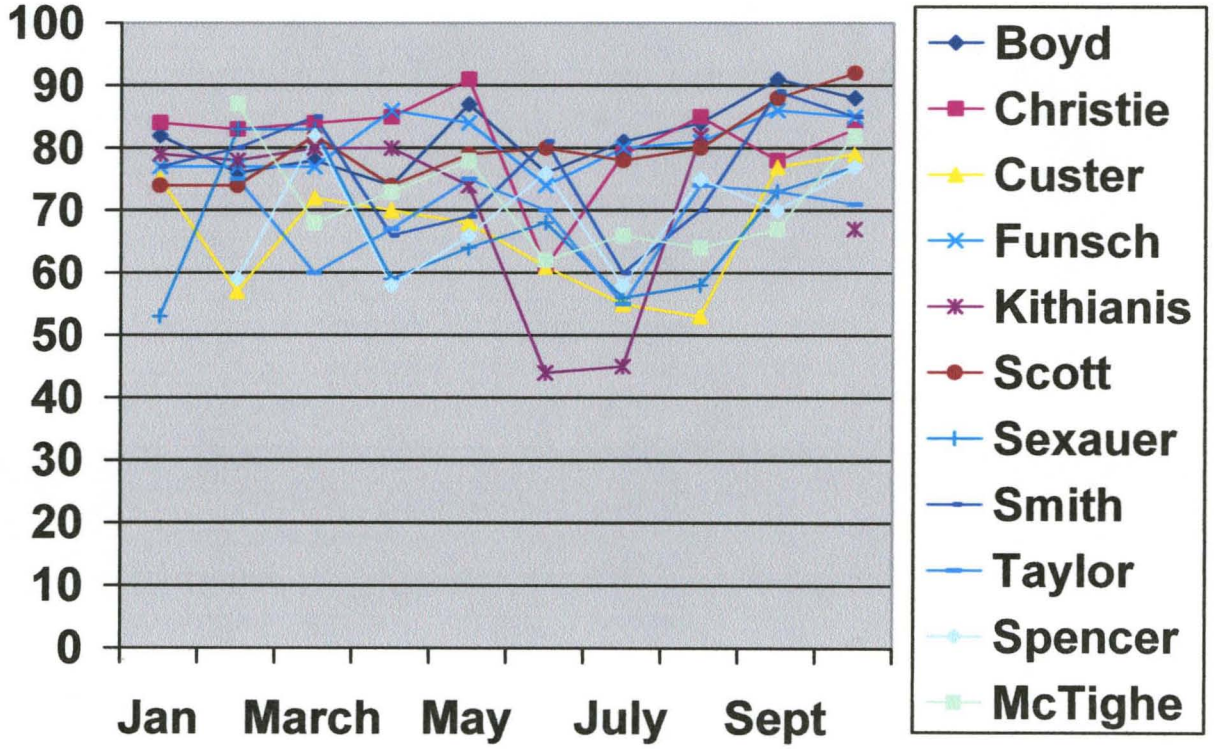
ATTACHMENT B

SHOW RATE IN PERCENTAGE FOR PHYSICIANS AT WEST ASHLEY CLINIC

Physician	1/08	2/08	3/08	4/08	5/08	6/08	7/08	8/08	9/08	10/08
Boyd	82	76	78	74	87	76	81	84	91	88
Christie	84	83	84	85	91	61	79	85	78	83
Custer	75	57	72	70	68	61	55	53	77	79
Funsch	77	77	77	86	84	74	80	81	86	85
Kithianis	79	78	80	80	74	44	45	82	X	67
Scott	74	74	82	74	79	80	78	80	88	92
Sexauer	53	83	83	59	64	68	56	58	73	77
Smith	77	80	85	66	69	81	60	70	89	85
Taylor		75	60	67	75	70	55	74	73	71
Spencer		59	82	58	66	76	58	75	70	77
McTighe		87	68	73	78	62	66	64	67	82

GRAPH OF SHOW RATE IN PERCENTAGES FOR PHYSICIANS



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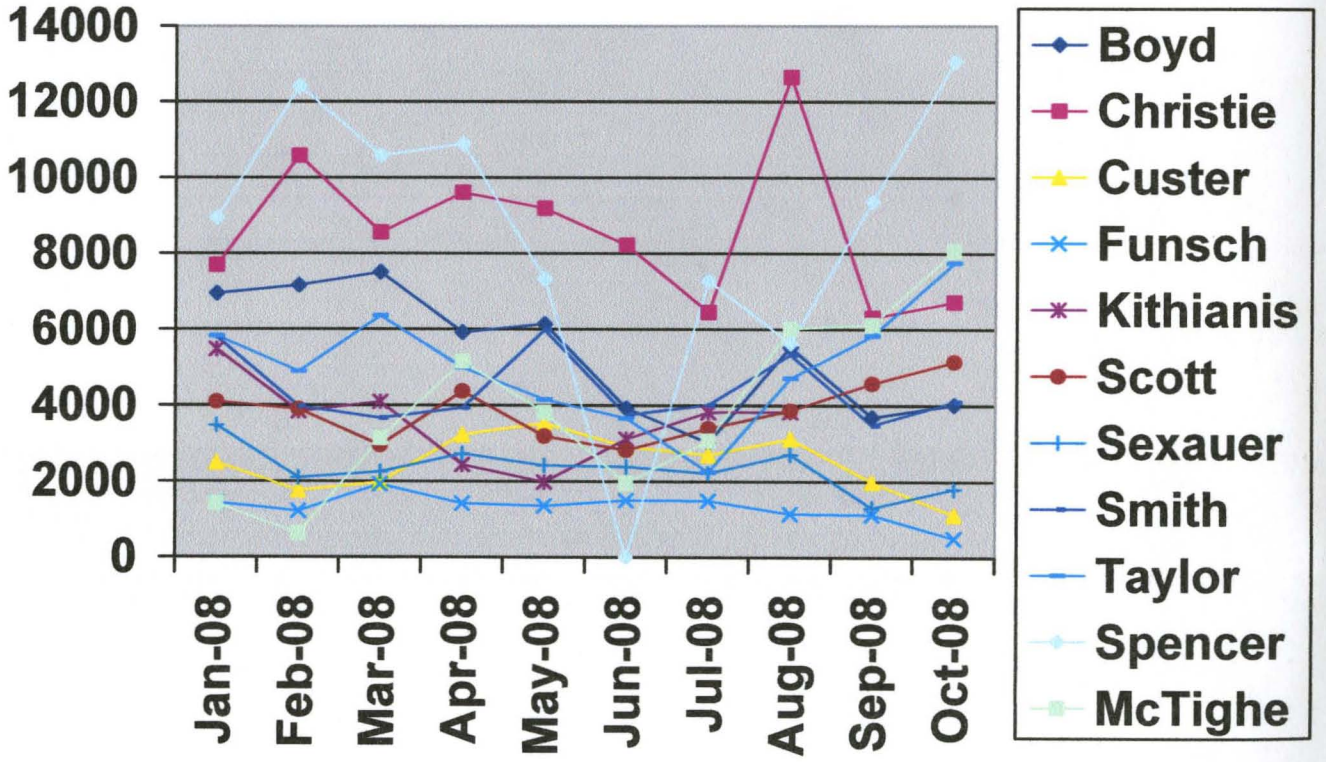
ATTACHMENT C

MEDICAID CHARGES IN DOLLARS BY PHYSICIANS AT WEST ASHLEY CLINIC

Physician	1/08	2/08	3/08	4/08	5/08	6/08	7/08	8/08	9/08	10/08	
Boyd	6951	7172	7516	5924	6144	3928	3017	5527	3688	4009	
Christie	7696	10588	8560	9608	9188	8216	6442	12650	6300	6717	
Custer	2492	1761	1984	3235	3534	2909	2698	3125	1984	1116	
Funsch	1438	1215	1926	1419	1348	1490	1488	1140	1116	496	
Kithianis	5480	3845	4099	2445	1984	3114	3819	3831	X		
Scott	4092	3904	2951	4373	3192	2824	3394	3857	4576	5146	
Sexauer	3472	2095	2251	2725	2418	2382	2207	2700	1302	1798	
Smith	5797	3975	3664	3940	5983	3744	4016	5327	3472	4092	
Taylor	5828	4891	6361	4990	4155	3663	2244	4708	5828	7743	
Spencer	8957	12425	10593	10903	7333	0	7280	5629	9364	13058	
McTighe	1426	633	3137	5166	3816	1949	3076	6015	6115	8068	

GRAPH OF MEDICAID CHARGES IN DOLLARS BY PHYSICIANS



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ATTACHMENT D
PERCENTAGE OF PRODUCTIVITY OF PHYSICIANS AT WEST ASHLEY CLINIC

Physician	1/08	2/08	3/08	4/08	5/08	6/08	7/08	8/08	9/08	10/08	
Boyd	51	56	56	50	63	57	56	55	53	49	
Christie	57	59	57	50	55	57	55	63	52	57	
Custer											contract
Funsch											contract
Kithianis	63	55	55	50	55	54	48	55	60		
Scott	68	65	69	64	66	63	64	62	68	64	
Sexauer											contract
Smith	53	60	57	56	58	60	59	60	58	60	
Taylor	62	68	63	60	68	63	69	68	59	69	
Spencer	56	61	50	56	58	AL	54	54	52	56	
McTighe	0	25	45	43	56	53	50	44	39	51	

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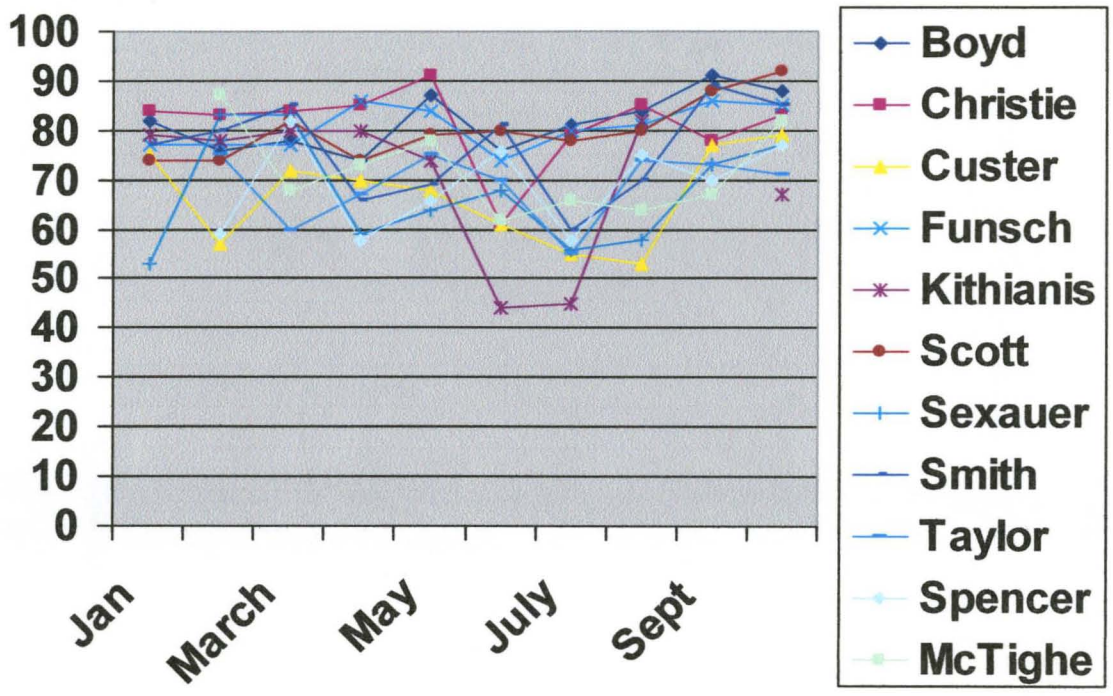
GRAPH OF PRODUCTIVITY IN PERCENTAGE OF PHYSICIANS



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